		FOR OHF USE					

LL1

2000
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2000)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0014258

Facility Name: ANCHORAGE OF BENSENVILLE

Address: 111 E. WASHINGTON STREET (Number) BENSENVILLE (City) 60106 (Zip Code)

County: DU PAGE

Telephone Number: (630) 766-5800 **Fax #** (630) 860-5130

IDPA ID Number: 36-2166970-001

Date of Initial License for Current Owners: 09/03/1905

Type of Ownership:

X	VOLUNTARY,NON-PROFIT		PROPRIETARY		GOVERNMENTAL		
X	Charitable Corp.		Individual		State		
	Trust		Partnership		County		
IRS Exemption Code	501(C)3		Corporation		Other		
			"Sub-S" Corp.				
			Limited Liability Co.				
			Trust				
			Other				

In the event there are further questions about this report, please contact:
Name: DONALD PRIMDAHL **Telephone Number:** (630) 521-8034

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 07/01/1999 to 07/01/2000 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider

(Signed) _____ (Date)

(Type or Print Name) THOMAS L. NOESEN, JR.

(Title) TREASURER

Paid Preparer

(Signed) _____ (Date)

(Print Name and Title)

(Firm Name & Address)

(Telephone) ( ) Fax # ( )

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 **Phone # (217) 782-1630**

Facility Name & ID Number ANCHORAGE OF BENSENVILLE # 0014258 Report Period Beginning: 07/01/1999 Ending: 07/01/2000

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	134	Skilled (SNF)	134	49,044	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4	96	Intermediate/DD	96	35,136	4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	230	TOTALS	230	84,180	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	29,308	17,931	8,001	55,240	8
9	SNF/PED					9
10	ICF	10,557	7,534		18,091	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	39,865	25,465	8,001	73,331	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 87.11%

D. How many bed-hold days during this year were paid by Public Aid?
0 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
HOME DELIVERED MEALS, NUTRITION SITE, STAFF FOOD SERVICES

F. Does the facility maintain a daily midnight census? YES

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [X] NO [ ]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [X] NO [ ]

I. On what date did you start providing long term care at this location?
Date started 1953

J. Was the facility purchased or leased after January 1, 1978?
YES [ ] Date _____ NO [X]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 50 and days of care provided 8,001

Medicare Intermediary ADMINASTAR

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 06/30/2000 Fiscal Year: 06/30/2000

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number ANCHORAGE OF BENSENVILLE # 0014258 Report Period Beginning: 07/01/1999 Ending: 07/01/2000

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger Salary/Wage 1	Supplies 2	Other 3	Total 4	Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY 9	10	
	A. General Services											
1	Dietary	546,475	104,765	290,871	942,111	6,251	948,362		948,362			1
2	Food Purchase		668,298		668,298	(6,198)	662,100	(200,730)	461,370			2
3	Housekeeping	382,131	79,723	217	462,071	719	462,790		462,790			3
4	Laundry	119,567	35,122	(2,948)	151,741		151,741		151,741			4
5	Heat and Other Utilities			297,898	297,898		297,898		297,898			5
6	Maintenance	162,359	58,971	119,671	341,001	(2,140)	338,861		338,861			6
7	Other (specify):*											7
8	**TOTAL General Services**	1,210,532	946,879	705,709	2,863,120	(1,368)	2,861,752	(200,730)	2,661,022			8
	B. Health Care and Programs											
9	Medical Director			14,127	14,127		14,127		14,127			9
10	Nursing and Medical Records	3,854,327	686,470	30,186	4,570,983	(78,490)	4,492,493		4,492,493			10
10a	Therapy	197,050	167	866,571	1,063,788	(862,995)	200,793		200,793			10a
11	Activities	207,617	6,230	35,812	249,659	65,810	315,469	(13,184)	302,285			11
12	Social Services	194,979	440	1,842	197,261		197,261		197,261			12
13	Nurse Aide Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	4,453,973	693,307	948,538	6,095,818	(875,675)	5,220,143	(13,184)	5,206,959			16
	C. General Administration											
17	Administrative	70,509			70,509	39,010	109,519	434,372	543,891			17
18	Directors Fees											18
19	Professional Services			341,592	341,592	(157,914)	183,678	65,233	248,911			19
20	Dues, Fees, Subscriptions & Promotions			39,196	39,196	2,261	41,457	(11,469)	29,988			20
21	Clerical & General Office Expenses	48,282	54,354	63,743	166,379	24,710	191,089	43,448	234,537			21
22	Employee Benefits & Payroll Taxes			1,537,974	1,537,974	11,922	1,549,896	116,906	1,666,802			22
23	Inservice Training & Education											23
24	Travel and Seminar			15,413	15,413	876	16,289	7,503	23,792			24
25	Other Admin. Staff Transportation			1,262	1,262	6,515	7,777	8,334	16,111			25
26	Insurance-Prop.Liab.Malpractice			29,502	29,502		29,502		29,502			26
27	Other (specify):*											27
28	**TOTAL General Administration**	118,791	54,354	2,028,682	2,201,827	(72,620)	2,129,207	664,327	2,793,534			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	5,783,296	1,694,540	3,682,929	11,160,765	(949,663)	10,211,102	450,413	10,661,515			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number ANCHORAGE OF BENSENVILLE #0014258 Report Period Beginning: 07/01/1999 Ending: 07/01/2000

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
	D. Ownership											
30	Depreciation			402,511	402,511		402,511	(32,845)	369,666			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			248,752	248,752		248,752	(1,448)	247,304			32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds					7,739	7,739		7,739			34
35	Rent-Equipment & Vehicles			100,700	100,700	(100,700)		2,252	2,252			35
36	Other (specify):*											36
37	**TOTAL Ownership**			751,963	751,963	(92,961)	659,002	(32,041)	626,961			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		24,588	33,925	58,513	1,029,853	1,088,366		1,088,366			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops					12,771	12,771		12,771			41
42	Provider Participation Fee			126,399	126,399		126,399		126,399			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**		24,588	160,324	184,912	1,042,624	1,227,536		1,227,536			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	5,783,296	1,719,128	4,595,216	12,097,640		12,097,640	418,372	12,516,012			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number ANCHORAGE OF BENSENVILLE # 0014258 Report Period Beginning: 07/01/1999 Ending: 07/01/2000

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Reference	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(200,730)	2		4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space	(13,040)	11		6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(32,845)	30		9
10	Interest and Other Investment Income	(1,448)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions	(144)	11		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(13,560)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule OUT OF STATE TRAVEL	(621)	24		29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (262,388)		$	30

OHF USE ONLY								
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(45,278)	VARIOUS	34
35	Other- Attach Schedule VIII-B	725,417	VARIOUS	35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 680,139		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ 417,751		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		X	$		38
39						39
40	Gift and Coffee Shops	X		12,771	VARIOUS	40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44	Exceptional Care Program	X		1,029,853	VARIOUS	44
45	Other-Attach Schedule		X			45
46	Other-Attach Schedule		X			46
47	**TOTAL (C): (sum of lines 38-46)**			$ 1,042,624		47

STATE OF ILLINOIS

ANCHORAGE OF BENSENVILLE

ID# 0014258

Report Period Beginning: 07/01/1999

Ending: 07/01/2000

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	ALLOCATION INDIRECT COST - SCHED VIII-I	$ 434,372	17	1
2	ALLOCATION INDIRECT COST - SCHED VIII-B	110,511	19	2
3	ALLOCATION INDIRECT COST - SCHED VIII-B	2,091	20	3
4	ALLOCATION INDIRECT COST - SCHED VIII-B	43,448	21	4
5	ALLOCATION INDIRECT COST - SCHED VIII-B	116,906	22	5
6	ALLOCATION INDIRECT COST - SCHED VIII-B	7,503	24	6
7	ALLOCATION INDIRECT COST - SCHED VIII-B	8,334	25	7
8	ALLOCATION INDIRECT COST - SCHED VIII-B	2,252	35	8
9				9
10				10
11				11
12				12
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82				82
83				83
84				84
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87				87
88				88
89				89
90	**Total**	725,417		90

STATE OF ILLINOIS

Summary A

Facility Name & ID Number ANCHORAGE OF BENSENVILLE # 0014258 **Report Period Beginning:** 07/01/1999 **Ending:** 07/01/2000

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(200,730)	0	0	0	0	0	0	0	0	0	0	(200,730)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(200,730)	0	0	0	0	0	0	0	0	0	0	(200,730)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	(13,184)	0	0	0	0	0	0	0	0	0	0	(13,184)	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	(13,184)	0	0	0	0	0	0	0	0	0	0	(13,184)	16
	C. General Administration													
17	Administrative	434,372	0	0	0	0	0	0	0	0	0	0	434,372	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	110,511	(45,278)	0	0	0	0	0	0	0	0	0	65,233	19
20	Fees, Subscriptions & Promotions	(11,469)	0	0	0	0	0	0	0	0	0	0	(11,469)	20
21	Clerical & General Office Expenses	43,448	0	0	0	0	0	0	0	0	0	0	43,448	21
22	Employee Benefits & Payroll Taxes	116,906	0	0	0	0	0	0	0	0	0	0	116,906	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	7,503	0	0	0	0	0	0	0	0	0	0	7,503	24
25	Other Admin. Staff Transportation	8,334	0	0	0	0	0	0	0	0	0	0	8,334	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	709,605	(45,278)	0	0	0	0	0	0	0	0	0	664,327	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	495,691	(45,278)	0	0	0	0	0	0	0	0	0	450,413	29

STATE OF ILLINOIS **Summary B**

Facility Name & ID Number **ANCHORAGE OF BENSENVILLE** **#** **0014258** **Report Period Beginning:** **07/01/1999** **Ending:** **07/01/2000**

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	(32,845)	0	0	0	0	0	0	0	0	0	0	(32,845)	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(1,448)	0	0	0	0	0	0	0	0	0	0	(1,448)	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	2,252	0	0	0	0	0	0	0	0	0	0	2,252	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	(32,041)	0	0	0	0	0	0	0	0	0	0	(32,041)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Centers**	0	0	0	0	0	0	0	0	0	0	0	0	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	463,650	(45,278)	0	0	0	0	0	0	0	0	0	418,372	45

Facility Name & ID Number ANCHORAGE OF BENSENVILLE # 0014258 Report Period Beginning: 07/01/1999 Ending: 07/01/2000

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
BENSENVILLE HOME SOCIETY	100	PEOTONE SENIOR LIVING CENTER	PEOTONE	LIFELINK AREA\		INDEPENDENT
LIFELINK CORP. (BHS PARENT)	100	ANCHORAGE OF BEECHER	BEECHER	HOUSING	VARIOUS	LIVING
		PINE ACRES LIVING CENTER	DEKALB	BRIDGEWAY OF		INDEPENDENT
				BENSENVILLE	BENSENVILLE	LIVING
				LIFELINK CHARITI	BENSENVILLE	FUND RAISING
				LIFELINK SERVICES	BENSENVILLE	PROJ. DEVEL.

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

	1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V		19	MANAGEMENT FEES	$ 83,033	LIFELINK CORP. (V.P. OF HEALTH CARE)	100.00%	$ 51,812	$ (31,221)	1
2	V		19	MANAGEMENT FEES	72,408	LIFELINK CORP. (PASTORAL CARE)	100.00%	66,788	(5,620)	2
3	V		19	MANAGEMENT FEES	65,230	BHS (VOLUNTEER COORDINATOR)	100.00%	57,113	(8,117)	3
4	V		19	MANAGEMENT FEES	3,285	BHS (INTERGENERATIONAL COORDINATOR)	100.00%	2,965	(320)	4
5	V									5
6	V									6
7	V									7
8	V									8
9	V									9
10	V									10
11	V									11
12	V									12
13	V									13
14	Total				$ 223,956			$ 178,678	$ * (45,278)	14

*** Total must agree with the amount recorded on line 34 of Schedule VI.**

Facility Name & ID Number ANCHORAGE OF BENSENVILLE # 0014258 Report Period Beginning: 07/01/1999 Ending: 07/01/2000

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 0	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number ANCHORAGE OF BENSENVILLE # 0014258 Report Period Beginning: 07/01/1999 Ending: 07/01/2000

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	CARL ZIMMERMAN	PRESIDENT	ADMIN.	NONE	28,178	12.78	31.95	SALARY	$ 35,144	17-7	1
2	ROBERT LOGSTON	EXEC. VP ADMIN.	ADMIN.	NONE	28,178	12.78	31.95	SALARY	35,144	17-7	2
3	JOAN DI LEONARDI	EXEC. VP OPER.	ADMIN.	NONE	28,178	12.78	31.95	SALARY	35,144	17-7	3
4	JAMES FORMAL	VP HEALTH CARE	ADMIN-HEALTH	NONE	77,000	12	30.00	SALARY	33,000	19-3	4
5	L. MANOR/T. NOESEN	VP FIN/TREASURE	ACCT/FINANCE	NONE	28,178	12.78	31.95	SALARY	35,144	17-7	5
6	M. CARLSON/A. GABRYS	CONTROLLER	ACCT/FINANCE	NONE	17,680	12.78	31.95	SALARY	22,050	17-7	6
7	JATHY LYNN CICERO	VP CORP. SERV.	ADMIN.	NONE	6,642	12.78	31.95	SALARY	8,284	17-7	7
8	KENYETTA HAYWOOD	VP SUPP. SERV.	SUPP. SERV.	NONE	28,178	12.78	31.95	SALARY	35,144	17-7	8
9	PAMELA JONES	DIR. - VOL.. SERV.	RECRUIT/PLACM	NONE	11,087	20	50.00	SALARY	18,479	11-7	9
10	DONALD PRIMDAHL	DIR. - BUDGETING	BDGT/GOVT. RE	NONE	18,511	12.78	31.95	SALARY	23,087	17-7	10
11	JANET HISBON	DIR. - PAST. CARE	SPRITUAL SERV	NONE	8,693	18.8	47.00	SALARY	18,570	11-7	11
12	KATHLEEN SCHUPBACH	DIR. - HUMAN RES.	PERSONNEL	NONE	12,504	12.78	31.95	SALARY	15,594	17-7	12
13								TOTAL	$ 314,784		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number ANCHORAGE OF BENSENVILLE # 0014258 Report Period Beginning: 07/01/1999 Ending: 07/01/2000

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	MELODY LEIMNETZER	DIR. - TRAINING	TRAINING	NONE	13,746	12.78	31.95	SALARY	$ 17,145	17-7	1
2	ROBIN MCBROOM	INTERGEN. COORD.	ACTIVITIES	NONE	3,142	2	5.00	SALARY	1,964	11-7	2
3											3
4								TOTAL PAGE 7	314,784		4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ 333,893		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number ANCHORAGE OF BENSENVILLE # 0014258 Report Period Beginning: 07/01/1999 Ending: 7/01/2000

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: LIFELINK CORPORATION
Street Address: 331 S. YORK ROAD
City / State / Zip Code: BENSENVILLE, IL. 60106
Phone Number: (630) 766-3570
Fax Number: (630) 860-5130

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	17	ADMINISTRATION	DIRECT PROG. COST	39,065,398	12	$ 1,359,577	$ 1,359,577	12,481,028	$ 434,372	1
2	19	PROFESSIONAL SERVICES	DIRECT PROG. COST	39,065,398	12	345,899		12,481,028	110,511	2
3	20	FEES, SUBSCRIPTIONS, PROM	DIRECT PROG. COST	39,065,398	12	6,545		12,481,028	2,091	3
4	21	GEN. OFFICE EXPENSE	DIRECT PROG. COST	39,065,398	12	135,993		12,481,028	43,448	4
5	22	EMP. TAXES & BENEFITS	DIRECT PROG. COST	39,065,398	12	365,915		12,481,028	116,906	5
6	24	TRAVEL & SEMINARS	DIRECT PROG. COST	39,065,398	12	23,482		12,481,028	7,502	6
7	25	OTHER STAFF TRANS.	DIRECT PROG. COST	39,065,398	12	26,084		12,481,028	8,334	7
8	35	RENTAL EQUIP.	DIRECT PROG. COST	39,065,398	12	7,048		12,481,028	2,252	8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 2,270,543	$ 1,359,577		$ 725,416	25

Facility Name & ID Number ANCHORAGE OF BENSENVILLE # 0014258 Report Period Beginning: 07/01/1999 Ending: 07/01/2000

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1	TAX EXEMPT BONDS		X	REFINANCE MORTGAGE	*	*	$ *	$ *	*	*	$ 248,752	1
2				& CAPITAL PROJECTS								2
3												3
4												4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related						$	$			$ 248,752	9
	B. Non-Facility Related*											
10												10
11							* SEE ATTACHED					11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$ 0	14
15	TOTALS (line 9+line14)						$ *	$ *			$ 248,752	15

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Facility Name & ID Number ANCHORAGE OF BENSENVILLE **#** 0014258 **Report Period Beginning:** 07/01/1999 **Ending:** 07/01/2000

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 1999 report.	$	0	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	$	0	2
3. Under or (over) accrual (line 2 minus line 1).	$		3
4. Real Estate Tax accrual used for 2000 report. (Detail and explain your calculation of this accrual on the lines below.)	$	0	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**	$	0	5
6. Subtract a refund of real estate taxes used previously to calculate a payment rate. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For 19 Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**	$	0	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	$	0	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	1995	0	8
	1996	0	9
	1997	0	10
	1998	0	11
	1999	0	12

FOR OHF USE ONLY

13	FROM R. E. TAX STATEMENT FOR 1999	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

Facility Name & ID Number ANCHORAGE OF BENSENVILLE # 0014258 Report Period Beginning: 07/01/1999 Ending: 07/01/2000

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 139,890 B. General Construction Type: Exterior BRICK Frame _____ Number of Stories 1

C. Does the Operating Entity? [X] (a) Own the Facility [ ] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [ ] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

BENSENVILLE HOME SOCIETY'S CHILD & FAMILY SERVICES/NORTH HOUSE BUILDING - OFFICE SPACE (51,307 SQ. FT.)
LIFELINK AREA HOUSING'S CASTLE TOWERS - LOW INCOME SENIOR CITIZENS & HANDICAPPED APARTMENTS (110,000SQ. FT. - 149 UNITS)
BENSENVILLE HOME SOCIETY'S MEADOW CREST UNITS - TOWN HOMES FOR SENIOR CITIZENS (12,500 SQ. FT. - 4 BUILDINGS/ 13 UNITS)
BRIDGEWAY OF BENSENVILLE - CCRC FOR SENIOR CITIZENS (206,400 SQ. FT. - 160 UNITS)

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred: _____ 2. Number of Years Over Which it is Being Amortized: _____

3. Current Period Amortization: _____ 4. Dates Incurred: _____

Nature of Costs: _____
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	LONG TERM CARE	789,200	PRE 1900	$ 14,628	1
2					2
3	TOTALS	789,200		$ 14,628	3

Facility Name & ID Number ANCHORAGE OF BENSENVILLE # 0014258 Report Period Beginning: 07/01/1999 Ending: 07/01/2000

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	46		1953	1953	$ 542,515	$ 8,346	30	$ 0	$ (8,346)	$ 542,515	4
5	137		1975	1975	3,200,989	80,025	40	80,025		1,954,199	5
6	47		1977	1977	906,521	22,663	40	22,663		521,250	6
7			1985	1985	148,230	4,941	30	4,941		74,115	7
8			1995	1995	789,192	31,566	30	26,306	(5,260)	155,407	8
	Improvement Type**										
9	1985 ADMINISTRATION BLDG. RENOVATION			1985	554,447	13,861	40	13,861		204,788	9
10	1986 ADMINISTRATION BLDG. RENOVATION			1986	42,723	1,068	40	1,068		14,681	10
11	FULLY DEPRECIATED				1,070,869	0	VAR	0		1,070,869	11
12	UNIT E HVAC AND PIPING			1983	11,290	0	20	565	565	9,599	12
13	ADMINISTRATION RENOVATION			1987	2,318	58	40	58		781	13
14	SIDEWALK AND PAVEMENT REPAIR			1988	14,491	0	20	725	725	8,695	14
15	ASPHALT REPAIRS			1989	49,263	2,463	16	3,079	616	30,790	15
16	CONCRETE REPAIRS			1989	31,335	0	20	1,566	1,566	17,234	16
17	CARPETING			1989	700	18	10	54	36	700	17
18	TILE RESIDENT ROOMS			1989	1,152	0	10	115	115	1,118	18
19	TRASH COMPACTOR			1989	9,117	455	10		(455)	9,117	19
20	AUTOMATIC SLIDING DOOR - CENTER LOUNGE			1989	11,116	556	10		(556)	11,116	20
21	UNITS C/D APPOLO BATH TUBS			1989	23,824	1,190	15	1,588	398	17,470	21
22	CONCRETE REPAIRS			1990	2,455	123	20	123		1,230	22
23	ROOF REPAIRS UNITS A/E			1990	13,011	1,084	8		(1,084)	13,011	23
24	UNITS A/D RENOVATION			1990	4,783	359	10		(359)	4,783	24
25	LOUNGE CARPET REPLACEMENT			1990	528	32	10		(32)	528	25
26	FITTING FOR DIESAL FUEL TANK			1990	2,965	296	20	148	(148)	1,481	26
27	SUN SHADE UNIT D			1990	5,288	529	10	529		5,157	27
28	RENOVATION UNIT D TUB ROOM			1990	2,205	220	8		(220)	2,205	28
29	UNIT E ELECTRIC PANEL			1990	12,692	635	20	635		6,350	29
30	BOILER ROOM REPAIRS			1990	4,726	237	20	236	(1)	2,361	30
31	ELECTRIC PANEL FOR EMERGENCY GENERATOR			1990	6,290	314	20	314		3,141	31
32	LAUNDRY RENOVATION			1990	243,583	24,358	20	12,179	(12,179)	116,716	32
33	HOTWATER TANK			1990	3,948	395	8		(395)	3,948	33
34	DINNING ROOM SOUND SYSTEM			1990	5,207	275	10	518	243	5,207	34
35	ROOF IMPROVEMENTS			1991	45,180	4,518	10	4,518		40,662	35
36	TOTAL (lines 4 thru 35)				$ 7,762,953	$ 200,585		$ 175,814	$ (24,771)	$ 4,851,224	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number ANCHORAGE OF BENSENVILLE # 0014258 Report Period Beginning: 07/01/1999 Ending: 07/01/2000

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	HVAC UPGRADE			1991	110,268	11,027	20	5,513	(5,514)	48,699	9
10	BACK FLOW PREVENTERS			1991	3,953	396	10	396		3,556	10
11	UNIT D HEAVY DUTY LIFTER			1991	1,275	127	15	85	(42)	765	11
12	LIBRARY COOLING SYSTEM			1991	1,200	120	8		(120)	1,200	12
13	HVAC UPGRADE			1992	32,784	3,278	20	1,639	(1,639)	14,752	13
14	REMODEL ICECREAM PARLOR			1992	11,388	1,139	20	569	(570)	5,121	14
15	MARKET PLACE/MURAL RENOVATION			1992	7,824	782	20	391	(391)	3,521	15
16	HANDICAPPED RAMPS			1992	55,125	5,512	10	5,512		44,102	16
17	REDECORATE UNITS A/E & CENTER LOUNGE			1992	15,439	1,544	8	1,446	(98)	15,439	17
18	REDECORATE ADMIN. OFFICE/CONF. ROOM			1992	8,290	829	8	779	(50)	8,290	18
19	GAS PIPING FOR LAUNDRY			1992	2,093	209	25	84	(125)	692	19
20	BIRD AVIARY			1992	6,780	678	10	678		5,424	20
21	REDECORATE STAFF DINNING ROOM			1992	5,852	585	8	547	(38)	5,852	21
22	ICECREAM PARLORCABINETS AND SINK			1992	3,239	324	20	162	(162)	1,350	22
23	CONCRETE REPAIRS			1993	5,465	547	20	273	(274)	2,185	23
24	INSTALL HVAC EQUIPMENT - MAINTENANCE			1993	15,570	1,557	20	779	(778)	5,971	24
25	INSTALL TILE - COMMON AREA			1993	15,647	1,565	8	1,956	391	14,833	25
26	BEATY SHOP RENOVATION			1993	21,100	2,110	8	2,638	528	20,004	26
27	ELECTRICAL WIRING - BOILER			1993	4,200	420	20	210	(210)	1,593	27
28	HEAVY DUTY DRAPES AND RODS			1993	2,887	289	10	289		1,998	28
29	UNIT C ELECTRIC LOCKING DOORS			1993	6,385	638	10	638		4,524	29
30	UNIT D CORRIDOR REDECORATION			1993	23,595	2,359	8	2,949	590	23,347	30
31	LAUNDRY MAGNETIC DOOR HOLDER			1993	500	50	10	50		354	31
32	CHAPEL RENOVATIONS			1993	41,100	4,110	8	5,138	1,028	38,967	32
33	RENOVATE FAMILY DINNING ROOM			1993	6,475	648	8	809	161	6,132	33
34	KITCHEN WIRING AND FLOOR REPAIR			1993	1,068	107	8	134	27	1,016	34
35	WALK-IN FREEZER COIL			1993	2,699	270	8	337	67	2,554	35
36	TOTAL (lines 4 thru 35)				$ 412,201	$ 41,220		$ 34,001	$ (7,219)	$ 282,241	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number ANCHORAGE OF BENSENVILLE # 0014258 Report Period Beginning: 07/01/1999 Ending: 07/01/2000

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	6 X 4 LAMP FIXTURES - REHAB/ACTIVITIES			1993	1,113	111	10	111		787	9
10	ACTIVITIES KILN VENT			1993	5,070	507	10	507		3,507	10
11	REPLACE GAS LINE TO FURNACE			1993	5,057	506	25	202	(304)	1,600	11
12	ASPHALT WORK			1994	6,720	672	16	420	(252)	2,695	12
13	BATHROOM AND COMMON AREA RENOVATION			1994	26,510	2,651	8	3,314	663	21,816	13
14	BOILER ROOM AIR UNIT			1994	10,754	1,075	10	1,075		8,601	14
15	KITCHEN RECEPTACLES			1994	2,081	208	10	208		1,144	15
16	ACTIVITY AREA RENOVATION			1994	19,905	1,990	8	2,488	498	16,380	16
17	(40) SECURITY LIGHT FIXTURES			1995	7,600	760	10	760		4,180	17
18	(2) PUSHER PLATES, RECEIVERS & TRANSFORMERS			1995	1,080	108	20	54	(54)	297	18
19	(153) PAIRS OF DRAPES			1995	32,900	3,290	10	3,290		18,095	19
20	DOOR ALARM SYSTEM			1995	7,752	775	20	388	(387)	1,972	20
21	UNIT C NURSING STATION			1995	2,700	270	10	270		1,238	21
22	REPLACE KITCHEN PLUMBING VALVES			1995	4,245	424	10	424		2,053	22
23	TILE WALK-IN FREEZER			1995	4,243	424	8	530	106	2,915	23
24	KITCHEN PRESSURE DUMPSTER PAD			1995	1,840	184	10	184		935	24
25	REWIRE SMOKE DETECTORS			1996	2,579	516	8	322	(194)	1,395	25
26	SECURITY SYSTEM			1996	28,298	2,830	10	2,830		12,735	26
27	UNIT D SHOWER RENOVATION			1996	21,625	2,162	10	2,162		8,831	27
28	SEAL PARKING AREAS			1997	7,997	800	16	500	(300)	1,542	28
29	NEW GARAGE/STORAGE BUILDING			1997	12,348	412	30	412		1,133	29
30	AWNING EXTENSION/ROOF			1997	2,769	92	30	92		192	30
31	(12) VARIABLE AIR VOLUME CONTROLERS - UNIT D			1998	11,700	1,170	30	390	(780)	878	31
32	KICON REINFORCED WALL BOARDS - KITCHEN			1998	4,092	409	10	409		920	32
33	S/S WALL PANEL - KITCHEN			1998	3,700	370	10	370		832	33
34	ELECTRICAL WORK - KITCHEN			1998	1,034	103	10	103		232	34
35	EXTERIOR LIGHTING			1998	2,230	74	10	223	149	443	35
36	TOTAL (lines 4 thru 35)				$ 237,942	$ 22,893		$ 22,038	$ (855)	$ 117,348	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number ANCHORAGE OF BENSENVILLE # 0014258 Report Period Beginning: 07/01/1999 Ending: 07/01/2000

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	3" VALVES AND PIPING / UNIT E			1998	3,000	300	10	300		625	9
10	BUILDING SAFTY UPGRADES			1998	798,672	79,867	10	79,867		126,456	10
11	STRUCTURAL RENOVATION			1999	60,642	2,022	30	2,022		2,190	11
12	FIRE PROTECTION SYSTEM - MAINTENANCE			1999	2,951	295	10	295		393	12
13	BURGLAR ALARM SYSTEM - MAINTENANCE			1999	8,330	833	10	833		1,041	13
14	ACOUSTICAL CEILING - KITCHEN			1999	2,000	200	10	200		250	14
15	ROOF REPLACEMENT			1999	115,966	5,798	20	5,798		5,798	15
16	CARPETING - CENTER LOUNGE			1999	25,796	2,580	10	2,580		2,580	16
17	STAFF DINING ROOM RENOVATION			1999	4,666	467	10	467		467	17
18	REFURBISH FLOOR - SUNDAES BEST			1999	3,275	273	10	273		273	18
19	DOMESTIC WATER BACKFLOW			2000	11,501	96	10	96		96	19
20	FOUNDATION STRUCTURAL REPAIRS			2000	57,165	238	20	238		238	20
21	AUTOMATIC DOOR CLOSERS - UNIT A			2000	20,110	168	10	168		168	21
22	REDECORATE UNIT D NURSING STATION			2000	14,665	122	10	122		122	22
23	VARIABLE AIR VOLUMNE BOX - UNIT D			2000	11,700	98	10	98		98	23
24	HVAC UNIT - UNIT D			2000	37,700	314	10	314		314	24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	TOTAL (lines 4 thru 35)				$ 1,178,139	$ 93,671		$ 93,671	$	$ 141,109	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number ANCHORAGE OF BENSENVILLE # 0014258 Report Period Beginning: 07/01/1999 Ending: 07/01/2000

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
37	Purchased in Prior Years	$ 397,114	$ 39,126	$ 39,126	$	5-10	$ 278,290	37
38	Current Year Purchases	59,175	1,252	1,252		5-10	1,252	38
39	Fully Depreciated Assets	491,633				5-10	491,633	39
40								40
41	TOTALS	$ 947,922	$ 40,378	$ 40,378	$		$ 771,175	41

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
42	RESIDENT TRANSP.	1997 DODGE RAM VAN	1997	$ 22,586	$ 3,764	$ 3,764	$	6	$ 10,665	42
43										43
44										44
45										45
46	TOTALS			$ 22,586	$ 3,764	$ 3,764	$		$ 10,665	46

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
47	Total Historical Cost	(line 3,col.4 + line 36,col.4 + line 41,col.1 + line 46,col.4)	$ 10,576,371	47
48	Current Book Depreciation	(line 36,col.5 + line 41,col.2 + line 46,col.5)	$ 402,511	48
49	Straight Line Depreciation	(line 36,col.7 + line 41,col.3 + line 46,col.6)	$ 369,666	49 **
50	Adjustments	(line 36,col.8 + line 41,col.4 + line 46,col.7)	$ (32,845)	50
51	Accumulated Depreciation	(line 36,col.9 + line 41,col.6 + line 46,col.9)	$ 6,173,762	51

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
52		$	$	$	52
53	NONE				53
54					54
55					55
56					56
57	TOTALS	$	$	$	57

G. Construction-in-Progress

	Description	Cost	
58	FOUNDATION REPAIR	$ 19,223	58
59	REMODEL STAFF DINING	4,666	59
60	SIGNAGE/CARPETING/CABLE	50,139	60
61		$ 74,028	61

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
   If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34.
   This amount was calculated by dividing the total amount to be amortized
   by the length of the lease ____.

9. Option to Buy: ☐ YES ☐ NO Terms: ____ *

10. Effective dates of current rental agreement:
    Beginning ____
    Ending ____

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2001	$
13.	/2002	$
14.	/2003	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☒ NO
16. Rental Amount for movable equipment: $ 94,198 Description: SEE ATTACHED
    (Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18	N/A				18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number ANCHORAGE OF BENSENVILLE # 0014258 Report Period Beginning: 07/01/1999 Ending: 07/01/2000

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD?
   - [ ] YES
   - [X] NO

   If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER AIDE ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER AIDE ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist		hrs	$		$	$		$	1
2	Licensed Speech and Language Development Therapist		hrs				82		82	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs				85		85	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescrpts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program					875,134			875,134	12
13	Other (specify): VENT CARE		2975	72,996				2,975	72,996	13
14	TOTAL			$ 72,996		$ 875,134	$ 167	2,975	$ 948,297	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

Facility Name & ID Number ANCHORAGE OF BENSENVILLE **#** 0014258 **Report Period Beginning:** 07/01/1999 **Ending:** 07/01/2000

XV. BALANCE SHEET - Unrestricted Operating Fund. **As of** 07/01/2000 **(last day of reporting year)**

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$	$ 571,108	1
2	Cash-Patient Deposits	39,807	184,448	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 649,258)	2,918,654	4,670,993	3
4	Supply Inventory (priced at COST)	30,092	63,961	4
5	Short-Term Investments		452,169	5
6	Prepaid Insurance	7,478		6
7	Other Prepaid Expenses		226,020	7
8	Accounts Receivable (owners or related parties)	831,414		8
9	Other(specify): GRANTS/CONTRIB. REC.		630,840	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 3,827,445	$ 6,799,539	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		921,501	13
14	Buildings, at Historical Cost		20,772,709	14
15	Leasehold Improvements, at Historical Cost		550,692	15
16	Equipment, at Historical Cost		6,185,171	16
17	Accumulated Depreciation (book methods)		(13,310,452)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): SEE ATTACHED		6,464,337	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$	$ 21,583,958	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 3,827,445	$ 28,383,497	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 603,584	$ 1,240,371	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	36,851	208,275	28
29	Short-Term Notes Payable		121,473	29
30	Accrued Salaries Payable	350,165	1,448,582	30
31	Accrued Taxes Payable (excluding real estate taxes)	14,342	48,016	31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	DUE TO AFFILIATED CORP.		8,324,617	36
37	BONDS PAYABLE/DEFERRED REV.		653,736	37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 1,004,942	$ 12,045,070	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable		733,800	39
40	Mortgage Payable			40
41	Bonds Payable		15,915,706	41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	DEFERRED REVENUE		427,471	43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$	$ 17,076,977	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 1,004,942	$ 29,122,047	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 2,822,503	$ (738,550)	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 3,827,445	$ 28,383,497	48

***(See instructions.)**

Facility Name & ID Number ANCHORAGE OF BENSENVILLE # 0014258 Report Period Beginning: 07/01/1999 Ending: 07/01/2000

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 3,957,079	1
2	Restatements (describe):		2
3	ELIMINATION OF AFFILIATED EQUITY	302,051	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 4,259,130	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(2,182,948)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe) NONE ALLOWED COSTS EXCLUDED	(381,606)	15
16	Other (describe) NET EXP. BOOKED ON CORP. BOOKS	1,127,927	16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (1,436,627)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 2,822,503	24 *

*** This must agree with page 17, line 47.**

Facility Name & ID Number ANCHORAGE OF BENSENVILLE # 0014258 Report Period Beginning: 07/01/1999 Ending: 07/01/2000

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 13,248,459	1
2	Discounts and Allowances for all Levels	(5,689,386)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 7,559,073	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	2,852,902	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 2,852,902	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop	12,771	12
13	Barber and Beauty Care		13
14	Non-Patient Meals	200,730	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 213,501	23
	D. Non-Operating Revenue		
24	Contributions	144	24
25	Interest and Other Investment Income***	1,448	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 1,592	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	BUS RENTAL REVENUE	13,040	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 13,040	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 10,640,108	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	2,863,120	31
32	Health Care	6,095,818	32
33	General Administration	2,201,827	33
	B. Capital Expense		
34	Ownership	751,963	34
	C. Ancillary Expense		
35	Special Cost Centers	58,513	35
36	Provider Participation Fee	126,399	36
	D. Other Expenses (specify):		
37	ALLOC. OF INDIRECT COST -SCHED. VIII B	725,416	37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 12,823,056	40
41	**Income before Income Taxes (line 30 minus line 40)****	(2,182,948)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (2,182,948)	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return?** NO **If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number ANCHORAGE OF BENSENVILLE # 0014258 Report Period Beginning: 07/01/1999 Ending: 07/01/2000

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,798	2,080	$ 61,211	$ 29.43	1
2	Assistant Director of Nursing	1,798	2,080	55,862	26.86	2
3	Registered Nurses	70,694	78,993	1,592,256	20.16	3
4	Licensed Practical Nurses	27,463	30,828	573,299	18.60	4
5	Nurse Aides & Orderlies	119,118	130,933	1,536,702	11.74	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	7,415	8,186	112,287	13.72	8
9	Activity Director	1,796	2,080	36,360	17.48	9
10	Activity Assistants	10,841	11,959	140,529	11.75	10
11	Social Service Workers	11,717	12,524	194,979	15.57	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook	3,892	4,306	55,566	12.90	14
15	Cook Helpers/Assistants	52,560	57,544	490,909	8.53	15
16	Dishwashers					16
17	Maintenance Workers	13,241	14,522	162,359	11.18	17
18	Housekeepers	40,997	45,365	382,131	8.42	18
19	Laundry	10,714	12,559	119,567	9.52	19
20	Administrator	1,912	2,080	70,509	33.90	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	4,993	5,881	48,282	8.21	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	11,103	12,484	119,760	9.59	31
32	Other Health Care(specify)					32
33	Other(specify) DRIVER	2,410	2,647	30,728	11.61	33
34	TOTAL (lines 1 - 33)	394,462	437,051	$ 5,783,296 *	$ 13.23	34

* This total must agree with page 4, column 1, line 45. ** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant		$		35
36	Medical Director	N/A	14,127	9-3	36
37	Medical Records Consultant	44	2,474	10-3	37
38	Nurse Consultant	N/A	4,744	10-3	38
39	Pharmacist Consultant	N/A	1,764	10-3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant	65	2,903	10a-3	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	36	1,816	11-3	44
45	Social Service Consultant	N/A	500	12-3	45
46	Other(specify)				46
47	DENTAL CONSULTANT	N/A	9,626	10-3	47
48					48
49	TOTAL (lines 35 - 48)	145	$ 37,954		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$		50
51	Licensed Practical Nurses				51
52	Nurse Aides				52
53	TOTAL (lines 50 - 52)		$		53

Facility Name & ID Number ANCHORAGE OF BENSENVILLE # 0014258 Report Period Beginning: 07/01/1999 Ending: 07/01/2000

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
JANE MULLER	ADMINISTRATOR	0	$ 70,509
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 70,509

B. Administrative - Other

Description	Amount
N/A	$
TOTAL (agree to Schedule V, line 17, col. 3)	$
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
LIFELINK CORP.	MANAGEMENT FEE	$ 223,956
LIFELINK CORP.	DATA PROCESSING	103,498
REINGRUBER & CO.	MEDICARE CONSULTANT	14,138
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 341,592

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 138,722
Unemployment Compensation Insurance	8,489
FICA Taxes	443,749
Employee Health Insurance	688,983
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
LIFE INSURANCE/DISABILITY INS.	29,370
PENSION (TSA)	205,598
VENT. BENEFITS RECLASSED	(15,340)
STAFF MEDICAL EXAMS	11,914
PROF. SOCIETIES/EMPLOYEE REL./ETC.	11,420
ALLOC. SCHED VII-B	26,991
ALLOC. SCHED VIII-B	116,906
TOTAL (agree to Schedule V, line 22, col.8)	$ 1,666,802

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
N/A		
TOTAL		$

* Attach copy of IMRF notifications

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	4,497
Health Care Worker Background Check	716
(Indicate # of checks performed 102)	
SUBSCRIPTIONS/REF. PUBL.	4,204
ASSOCIATION DUES	16,219
PUBLIC RELATIONS	7,019
PROGRAM PROMOTION	6,541
ALLOC. SCHED VII-B	2,261
ALLOC. SCHED VIII-B	2,091
Less: Public Relations Expense	(7,019)
Non-allowable advertising	(6,541)
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 29,988

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$ 621
In-State Travel	
Seminar Expense	15,143
ALLOC. SCHED VII-B	525
ALLOC. SCHED VIII-B	7,503
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 23,792

**See instructions.

Facility Name & ID Number ANCHORAGE OF BENSENVILLE # 0014258 Report Period Beginning: 07/01/1999 Ending: 07/01/2000

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY1997	FY1998	FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005
1			$		$	$	$	$	$	$	$	$	$
2													
3													
4	NONE												
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Number ANCHORAGE OF BENSENVILLE **#** 0014258 **Report Period Beginning:** 07/01/1999 **Ending:** 07/01/2000

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **NO**

(2) Are there any dues to nursing home associations included on the cost report? **YES**
If YES, give association name and amount. **LSN/AAHSA $7,540**

(3) Did the nursing home make political contributions or payments to a political action organization? **NO** If YES, have these costs been properly adjusted out of the cost report?

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **NO** If YES, what is the capacity?

(5) Have you properly capitalized all major repairs and equipment purchases? **YES**
What was the average life used for new equipment added during this period? **5-10 YRS**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **47,557** Line **10-2**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **YES** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **NO**
If YES, give effective date of lease.

(9) Are you presently operating under a sublease agreement? YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $ **126,399**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **NO** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **YES**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **NO** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **0** Has any meal income been offset against related costs? **NO** Indicate the amount. $ **0**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **NO**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **NO** If YES, please indicate the amount of income earned from such a program during this reporting period. $
c. What percent of all travel expense relates to transportation of nurses and patients? **NONE**
d. Have vehicle usage logs been maintained? **YES**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **YES**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **YES**
g. Does the facility transport residents to and from day training? NO
Indicate the amount of income earned from providing such transportation during this reporting period. $ **0**

(17) Has an audit been performed by an independent certified public accounting firm? **YES**
Firm Name: **ARTHUR ANDERSEN & CO.** The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? **NO** If no, please explain. **AUDIT HAS NOT BEEN ISSUED.**

(18) Have all costs which do not relate to the provision of long term care been adjusted out out of Schedule V? **YES**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **YES**
Attach invoices and a summary of services for all architect and appraisal fees.